FREDERICK COUNTY PUBLIC SCHOOLS/FREDERICK COUNTY HEALTH DEPARTMENT

TREATMENT AUTHORIZATION FORM

This order is valid only for the current school year_____ (Including Summer Session)

OR

Start Date: ____/____/_____ to Stop Date: _____/____/____

This treatment authorization form must be completed fully in order for staff to administer required treatment. A new form must be completed at the beginning of each school year.

HEALTH CARE PROVIDER AUTHORIZATION

Name of Student:	Date of Birth:
Allergies:	Grade:
Primary Diagnosis:	
Medical Treatment to be Administered:	
Time of Administration:	If PRN, frequency:
Health Care Provider's Name/Title: (Type or Print)	
Telephone: / Fax:	Use for Health Care Provider's Address Stamp
Address:	
Health Care Provider's Signature: / Date:	

PARENT/GUARDIAN AUTHORIZATION

I request designated staff to administer the medical treatment as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of a medical treatment at school

Parent/Guardian Signature:	Date:
Parent/Guardian Phone:	Work Phone:

SELF-ADMINISTRATION OF TREATMENT AUTHORIZATION/APPROVAL

Self-administration of medical treatment must be authorized by the health care provider and approved by the school registered nurse.

Health care provider's authorization for: Self-administration: □Yes □ No	Signature:	Date:
School registered nurse approval for: Self-administration: □Yes □ No	Signature:	Date:
Order reviewed and signed by school registered nurse:		Date: